

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00211161.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00209267.</p> <p>Complaint IN00211161 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00209267 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 27, 28, 29, 30, October 3 and 4, 2016.</p> <p>Facility number: 000166 Provider number: 155265 AIM number: 100267080</p> <p>Census bed type: SNF: 8 SNF/NF: 85 Total: 93</p> <p>Census payor type: Medicare: 12 Medicaid: 64 Other: 17 Total: 93</p> <p>Sample: 7</p> <p>Kindred Transitional Care and Rehab - Wedgewood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>16.2-3.1 in regard to the Investigation of Complaint IN00211161.</p> <p>Quality review completed by 34233 on October 6, 2016.</p> <p>Survey dates: July 12 and 13, 2016.</p> <p>Facility number: 000059 Provider number: 155697 AIM number: 100266560</p> <p>Census bed type: SNF: 06 SNF/NF: 63 Total: 69</p> <p>Census payor type: Medicare: 11 Medicaid: 42 Other: 16</p>	F 000			

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F 000	Continued From page 2 Total: 69 Sample: 3	F 000			